

**Core and Preventive Home and Community Based Services Form  
Specialized Supply, Special Medical Equipment, and Home Modifications**

GW-SF  
1-25-10

Recipient Name: \_\_\_\_\_ MID# \_\_\_\_\_

Name of Physician/RNP: \_\_\_\_\_

1. Check One:  Core Services  Preventive Services

**Specialized Supply** ( Minor Assistive Devices): Please see definition (GW-AD1). Please note this service is available for recipients on Core and Preventive Services [HCPCS Code T2028].

**Special Medical Equipment**: Please see attached definition (GW-SM). Please note this service is available for recipients on Core Services only. Attach form (GW-EM1) [HCPCS Code T2029].

**Home Modifications**: Please see attached definition (GW-EM). Please note this service is available for recipients on Core Services only. Attach form (GW-EM1) [HCPCS Code S5165].

2. Description of Service(s) Requested: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Justification for Request (attach Form GW-EM1 if required): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Recommended by (check all that apply):  Physician  PT/OT  RN  DHS SCW  Other

(If other, please provide Title/Credentials) \_\_\_\_\_

**By submitting and signing this form, the above professional ensures the following:**

- No other payer: The equipment or modification(s) are not otherwise available through Medicare, Medicaid, or other private insurance coverage.
- Effectiveness: Skilled professionals (e.g. PTs, OTs, Mobility Specialists) have properly identified the individual's need for the recommended equipment and/or modifications. Furthermore, the recommendation complies with the Limitations and Special Considerations as defined by the Rhode Island Global Waiver for Minor Assistive Devices, Special Medical Equipment or Environmental Modifications.

Name of Professional (print) \_\_\_\_\_ Tel. # \_\_\_\_\_ Fax # \_\_\_\_\_

Signature of Professional \_\_\_\_\_ Date \_\_\_\_\_ LTC RL \_\_\_\_\_

**-For Official Use Only-**

The above request is:  Approved  Denied Cost \$ \_\_\_\_\_

Reason for denial: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Attention DME Providers/Professionals: This Form must be attached to the Prior Authorization request from vendor.**